CONSULTANT REGISTRATION
AGENCY - AFFILIATED

Consultant Name: _____ ____ _____
First Name MI Last Name

Medicaid Provider Number for CDC+: ___ ___ ___ ___ ___ ___ ___ ___ ___

Agency Affiliation: _____
Agency's Complete Name

Agency's CDC+ Medicaid Group Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Mailing Address: _____

_____

_____ _____ _____
City State Zip Code

Work Number: _____

Cell Number: _____

Fax Number: _____

E-Mail Address: _____

Date of Introductory CDC+ Training: _____
mm/day(s)/yy

OFFICE USE ONLY	INITIAL	DATE
Received by Area Office		
Sent to Central Office		
Received by Cent. Office		
Assigned to		
Entered into Registry		

I have applied for a Specialty Code for CDC+ Consultant Services.

Signature:_____ Date: _____

CDC+ MOA between the above Agency and the APD Area _____ Office has been executed.

CDC+ Area Liaison Signature:_____ Date: _____

Instructions: *This form is to be completed before a CDC+ consumer can select you as his or her CDC+ consultant.* Complete the entire form. **Please print legibly!**

Your Medicaid Provider Number is a 9-digit number. Effective immediately, this number is the same as your Medicaid Provider Number for waiver support coordination services. You must have requested through File Maintenance for a Specialty Code for CDC+ to be added to your Medicaid file. That specialty code authorizes you to provide and bill Medicaid for consultant services provided to CDC+ consumers who are actively managing a monthly budget.

Your name, your agency name and your mailing address provided above must be the same as they are in the Florida Medicaid Management Information System (FMMIS) unless your agency permits you to receive program mail at a different address. Please use your registered name on all official CDC+ paperwork.

Complete and sign a Memorandum of Agreement (MOA) to provide Consultant Services for the CDC+ Program only if you are authorized to bind your agency contractually. Otherwise, an officer of your agency must have signed an MOA with the Area Administrator in the APD area in which you wish to provide services.

Please submit this completed form to the APD Area CDC+ Liaison for processing. Thank you.